CHILD MALTREATMENT DEATH INVESTIGATIONS IN VIRGINIA DURING STATE FISCAL YEAR 2020

Prepared by:
Child Protective Services Program

August 2021

VIRGINIA DEPARTMENT OF
SOCIAL SERVICES

Table of Contents

CHILD DEATH INVESTIGATIONS
DURING STATE FISCAL YEAR 2020

EXECUTIVE SUMMARY

This is a report on child deaths that were reported to local departments of social services (LDSS) and investigated during State Fiscal Year (SFY) 2020. This report includes a synopsis of data for all child abuse or neglect fatalities for SFY 2020, including demographic information pertaining to the victims, alleged abuser/neglector (s) and households impacted by those fatalities. It also highlights changes or trends from previous years. The information is used to evaluate and modify Virginia Department of Social Services (VDSS) policies, guidance, procedures and best practices where warranted.

The purpose of this report is to provide information on all child deaths that were investigated, with an emphasis on those deaths that occurred as a result of substantiated abuse or neglect. This report includes two appendices. Appendix A provides details for investigations that resulted in a founded disposition; Appendix B provides details of investigations that resulted in unfounded dispositions. A founded disposition means that a preponderance of the evidence demonstrates that child maltreatment occurred. This determination is based primarily upon first source, or direct evidence. A disposition of unfounded means there was not a preponderance of the evidence to warrant a founded disposition.

Preliminary Summary of Findings

In SFY 2020:

- LDSS investigated 139 child deaths suspected of being caused by abuse or neglect.
- There were 42 children whose deaths were the result of abuse or neglect.
- There were 93 investigations that resulted in an unfounded disposition; four investigations were incomplete at the time of this report.
- Fifty-nine LDSS conducted at least one child death investigation.
- The child death rate in Virginia decreased to 2.2 deaths per 100,000 children in SFY 2020. This rate is below the national death rate of 2.5 deaths per 100,000 children.
- The Eastern Region investigated the most child deaths (57), while the Northern Region experienced the highest rate of child deaths (6.2 deaths per 100,000 children).
- Children who died as a result of abuse or neglect ranged in age from birth to 17 years with more than 88% who were three and under.
- More male children (26) died from abuse or neglect than female children (16).

- The race of the children who died as a result of abuse or neglect included 48% who were White; 38% who were African American and 12% who were Multi-Racial.
- Fifty-five caretakers were determined to be responsible for the death of 42 children.
- Thirty of the caretakers were female and 21 were male.
- Sixty-nine percent (69%) of the 55 caretakers were biological parents, and 27 (49%) of them were less than 30 years of age.
- Twenty-eight (67%) of the 42 abuse-or-neglect-related child deaths involved physical neglect, and 13 (31%) child deaths involved physical abuse. Some children died from more than one type of abuse and/or in combination with physical neglect or medical neglect.
- A child was removed and placed into foster care in one household out of the 28 families who had other children in the home at the time of the child death.
- There were 42 households where child deaths were found to be the result of abuse or neglect; 21 families (50%) had prior or active child welfare involvement.

Noteworthy Trends

The rate of child deaths in the Northern Region increased more than five percent from SFY 2018, which is indicative of the region having the highest population. The race of caretakers was significantly closer in SFY 2020 than previous years (45% African-American and 44% White).

I. CHILD DEATHS

LDSS conducted 139 investigations involving 139 child deaths suspected of being caused by child maltreatment in SFY 2020. LDSS determined that 42 children died as a result of abuse or neglect; 93 children were in unfounded reports; and four reports were pending at the time of this report.

The Eastern Region investigated the most reports (57) followed by Piedmont (27), Central (22) and Northern (22) and Western (11).

As highlighted in Table 1, 59 (49%) of the 120 LDSS investigated at least one child death. Newport News (12), Virginia Beach (10) and Chesapeake (9) had the highest number of investigations, not all of which were founded.

Table 1: Dispositions of CPS Complaints with a Child Death by Locality
SFY 2020

LDSS	Founded	Unfounded	Pending/Appeal	Grand Total
Accomack		1		1
Albemarle		1		1
Alleghany		1		1
Amelia	1			1
Amherst		1		1
Bedford Co.	1	1		2
Campbell	1			1
Charlottesville		1		1
Chesapeake	2	6	1*	9
Chesterfield	2	6		8

Culpeper	1	1		2
Danville	1	1		2
Dinwiddie	1	2		3
Fairfax Co	1			1
Fauquier		3		3
Fluvanna		1		1
Franklin City		2		2
Frederick	1			1
Fredericksburg		1		1
Giles		1		1
Hanover	1			1
Henrico		1		1
Henry		1		1
James City		1		1
King William		1		1
Lee		1		1
Loudon		3		3
Lynchburg	6			6
Matthews		1		1
Mecklenburg		1		1
New Kent		1	1	2
Newport News	1	10	1	12
Norfolk	3	5		8
Norton	1			1
Orange		2		2
Page	1			1
Patrick		1		1
Petersburg	2	1		3
Pittsylvania		2		2
Portsmouth	3	1	1*	5
Prince George		2		2
Radford	1			1
Richmond City	2	1		3
Roanoke City	1	4		5
Roanoke County		1		1
Rockingham		3		3
Russell		2		2
Scott		1		1
Shenandoah		3		3
Spotsylvania		1		1
Stafford	1			1
Suffolk	2	1		3
Tazewell		1		1
Virginia Beach	4	6		10
Warren		1		1
Washington		1		1
Winchester		1		1
Wythe	1			1
York		1		1
GRAND TOTAL	**42**	**93**	**4**	**139**

Sources: VDSS, July 2021. Information obtained from LDSS

Two investigations could not be completed due to relocation (unknown) of alleged abuser during the investigation and no authorization by the alleged abuser to release hospital records.

As exhibited in Table 2, the percentages of **founded** versus **unfounded** dispositions involving child fatalities decreased for founded (30.2%) and increased for unfounded (67%) dispositions. The percentage of **all** investigations in SFY 2020 was approximately 40.3% founded and 59.6% unfounded.[1]

Table 2: Dispositions of Child Death Investigations
SFY 2018 - SFY 2020

	SFY 2018		SFY 2019		SFY 2020	
	Number	**Percent**	**Number**	**Percent**	**Number**	**Percent**
Founded	40	34.0	51	35.4	42	30.2
Unfounded	71	60.1	89	62.0	93	67.0
Pending/Appealed	7	6.0	4	2.7	4*	3.0
Total	**118**	**100.0**	**144**	**100.1**	**139**	**100.0**

Sources: VDSS, July 2021. Information obtained from LDSS.
Two investigations could not be completed due to relocation (unknown) of the alleged abuser during the investigation and no authorization by the alleged abuser to release hospital records.

As shown in Table 3, the death rate for children who died from abuse or neglect decreased from SFY 2019. According to the National Child Abuse and Neglect Data System (NCANDS) 2019 Child Maltreatment Report the national estimate of child deaths due to maltreatment has increased 10.8% since FFY 2015. While there are fluctuations from year to year, the increase is attributed to the implementation of child death reviews, expansion of the scope of existing reviews, improved monitoring as well as consultation of data sources outside of Child Protective Services (CPS). Due to the relatively low frequency of child fatalities, the national rate is sensitive to which states report this data and changes in the child population estimates produced by the U. S. Census Bureau.[2]

Table 3: Death Rate of Children in Virginia Due to Abuse or Neglect SFY 2010 – SFY 2020

SFY	Death Reports Investigated	Deaths Due to Abuse/Neglect	Death Rate (per 100,000	National Death Rate**
2010	78	44	2.4	2.3
2011	86	30	1.6	2.0
2012	107	37	2.0	2.1
2013	105	33	1.8	2.2
2014	124	47	2.5	2.0
2015	131	52	2.8	2.1
2016	129	46	2.5	2.3
2017	124	46	2.5	2.3
2018	118	40	2.1	2.3
2019	144	51	2.7	2.4
2020	**139**	**42**	**2.2**	**2.5**

*Death rate is calculated as number of deaths due to abuse/neglect divided by the state child population (2019 = 1,865,699)
Sources: VDSS, July 2021, Kids Count Data Center from the Annie E Casey Foundation
** Source: *Child Maltreatment 2019.* U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau.

[1] 14,900 investigations completed; 6,013 founded (40.3%); 8,887 unfounded (59.6%); and 216 other (1.4%). Source: Virginia Child Welfare Outcome Reports Version 4.88 (August 2021).
[2] Source: *Child Maltreatment 2019*. U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau.

As highlighted in Table 4, the Eastern Region conducted the most investigations of child deaths. The percentage of founded versus unfounded child death investigations varied by region, as well as the percentage of founded versus unfounded in *all* investigations.[3]

The *Code of Virginia*, specifically § 63.2-1505 B5, grants certain exceptions to the time frame for completing child death investigations, when such investigations require reports or records that are generated outside of the local department, such as an autopsy report. The time needed to obtain these reports or records is not counted towards the 45/60/90 day timeframes. The records must be necessary to complete the investigation and not available due to circumstances beyond the control of the local department. In SFY 2020, this accounted for four pending investigations.

Table 4: Child Fatality Investigations and Outcomes by Region
SFY 2020

	Founded		Unfounded		Pending		Appealed		Total	
	#	%	#	%	#	%	#	%	#	%
Central	9	41.0	12	54.5	1	4.5	0	0.0	22	100.0
Eastern	15	26.3	39	68.4	3*	5.2	0	0.0	57	100.0
Northern	5	23.0	17	77.2	0	0.0	0	0.0	22	100.0
Piedmont	10	37.0	17	63.0	0	0.0	0	0.0	27	100.0
Western	3	27.2	8	72.7	0	0.0	0	0.0	11	100.0
Statewide	**42**	**30.2**	**93**	**67.0**	**4**	**3.0**	**0**	**0.0**	**139**	**100.0**

Sources: VDSS, July 2021. Information obtained from LDSS.
Two investigations could not be completed due to relocation of the alleged abuser during the investigation and no authorization by the alleged abuser to release hospital records

VDSS also reports by region the ratio of child deaths to the population of children less than 18 years of age, as well as examines the number of child deaths and the percentages of founded investigations.

As exhibited in Table 5, the rate of child deaths per 100,000 children has increased in the Eastern and Northern Regions since SFY 2018. It should be noted that an increase of one or two child deaths would have a more significant impact on regions with a low child population (i.e. the Western Region) versus a region with a high child population (i.e. the Eastern Region).

Table 5: Child Deaths Due to Abuse or Neglect and Rates by Region
SFY 2018-SFY 2020

	SFY 2018		SFY 2019		SFY 2020	
	Deaths	Rate (Per 100,000)	Deaths	Rate (Per 100,000)	Deaths	Rate* (Per 100,000)
Central	7	2.3	14	4.8	9	**3.0**
Eastern	14	3.4	13	3.2	15	**3.7**
Northern	7	0.8	3	3.8	5	**6.2**
Piedmont	8	3.4	10	4.8	10	**4.2**
Western	4	3.8	11	10.2	3	**2.8**

Sources: VDSS, July 2021. Information obtained from LDSS. Kids Count Data Center from the Annie E Casey Foundation. *The population data used to determine rate per 100,000 for children <18 years of age by region are: Central: 294,304; Eastern: 408,211; Northern: 801,031; Piedmont: 236,312; Western: 105,704.

[3] The percentages for founded investigations by region: Central- 10.32%; Eastern- 12.31%; Northern- 9.39%; Piedmont-9.7%; Western- 10.57%. Source: Virginia Child Welfare Outcome Reports Version 4.88 (August 2021).

II. CHILDREN

LDSS investigated the deaths of 139 children in SFY 2020; and 42 children were found to have died as a result of abuse or neglect. This section provides detailed demographic information and trends for the children involved in child death investigations and whose deaths were determined to be the result of abuse or neglect.

As highlighted in Table 6, children from birth to three years continue to be the most vulnerable to die as abuse or neglect. Virginia's percentage for SFY 2020 was 88%, which is higher than the percentage throughout the country. Nationally, 70.3% of all child fatalities in FFY 2019 were children younger than three years of age.[4]

Table 6: Children Who Died From Abuse or Neglect by Age
SFY 2018 – SFY 2020

	SFY 2018		SFY 2019		SFY 2020	
	Number	**Percent**	**Number**	**Percent**	**Number**	**Percent**
Birth to 12 months	19	48.0	24	47.0	29	69.0
13 months to 3 years	11	28.0	14	27.4	8	19.0
4 to 7 years	4	10.0	5	10.0	1	2.4
8 to 12 years	3	7.0	3	5.9	3	7.1
13 to 17 years	3	7.0	5	10.0	1	2.4
Total	**40**	**100.0**	**51**	**100.3**	**42**	**100.0**

Sources: VDSS, July 2021. Information obtained from LDSS.

As shown in Table 7, there were significantly more male child deaths than female in SFY 2020. This is consistent with the national data which indicates that boys experienced a higher fatality rate (2.98 per 100,000) than girls (2.20 per 100,000).[5]

Table 7: Children Who Died From Abuse or Neglect by Gender
SFY 2018 – SFY 2020

	SFY 2018			SFY 2019			SFY 2020		
	#	**%**	**Rate (per 100,000)**	**#**	**%**	**Rate* (per 100,000)**	**#**	**%**	**Rate* (per 100,000)**
Female	11	28.0	1.2	19	37.3	2.1	16	38.0	1.7
Male	29	73.0	3.0	32	63.0	3.3	26	62.0	2.7
Total	**40**	**100.0**	**2.1**	**51**	**100.3**	**2.7**	**42**	**100.0**	**2.2**

Sources: VDSS, July 2021. Information obtained from LDSS. Kids Count Data Center from the Annie E Casey Foundation.
*The population data used to determine rate per 100,000 for children <18 years of age was females: 910,010 and males: 950,838.

[4,5] Source: *Child Maltreatment 2019*. U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau.

As exhibited in Table 8, 48% of the child fatalities in Virginia were White and 38% were African-American. The disproportionate rate of African-American child deaths in Virginia (2 times greater) is slightly below the national data (more than 2 times greater).[6]

Table 8: Children Who Died From Abuse or Neglect by Race
SFY 2018 – SFY 2020

	SFY 2018		SFY 2019		SFY 2020		
	Number	**Percent**	**Number**	**Percent**	**Number**	**Percent**	**Rate* (per 100,000)**
African-American	18	45.0	19	37.2	16	38.0	43.3
White	20	50.0	29	57.0	20	48.0	20.2
Multi-racial	1	2.5	2	4.0	5	12.0	46.5
Asian	0	0.0	1	2.0	0	0	0
Unknown	1	2.5	0	0.0	1	2.0	n/a
Total	**40**	**100.0**	**51**	**100.0**	**42**	**100.0**	**2.6**

Sources: VDSS, July 2021. Information obtained from LDSS. Kids Count Data Center f/t Annie E Casey Foundation. *The population data used to determine rate per 100,000 for children <18 years of age was African American: 369,359; White: 988,011; multi-racial: 107,348 Asian: 120,443; total: 1,598,256.

III. CARETAKERS

As shown in Table 9, LDSS determined that there were 55 caretakers responsible for the deaths of 42 children due to abuse or neglect in SFY 2020. Twelve victims were abused or neglected by two different caretakers and one victim was abused or neglected by three different caretakers. The majority of caretakers (69%) were the biological parents, which is below the national data (79.7%) that indicates the parents acted alone, together or with other individuals. Caretakers include childcare providers who are both regulated (licensed) and unregulated (unlicensed).

CPS investigates child fatalities that are suspicious for abuse or neglect committed by a caretaker **only**.

[6] Source: *Child Maltreatment 2019*. U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau.

Table 9: Caretakers in Child Deaths from Abuse or Neglect
SFY 2018 – SFY 2020

	SFY 2018		SFY 2019		SFY 2020	
	Number	**Percent**	**Number**	**Percent**	**Number**	**Percent**
Mother	29	52.0	33	45.0	22	40.0
Father	8	14.2	22	30.0	16	29.0
Stepparent	1	1.8	3	4.0	0	0.0
Grandparent	3	5.4	2	2.7	1	2.0
Uncle/Aunt	2	3.6	1	1.3	0	0.0
Paramour	7	13.0	6	8.1	6	11.0
Childcare Provider	0	0.0	3	4.0	4	7.3
Foster Parent	0	0.0	0	0.0	1	2.0
Legal Guardian	0	0.0	0	0.0	0	0.0
Other adult in home	4	7.1	4	5.4	0	0.0
Sibling	0	0.0	0	0.0	1	2.0
Unknown	2	3.6	0	0.0	4	7.3
Total Caretakers	**56**	**100.0**	**74**	**100.0**	**55**	**100.0**

Source: VDSS, July 2021. Information obtained from LDSS.

Nationally, more than 16 percent (16.6%) of fatalities did not have a parental relationship to their perpetrator.[7] Sometimes the identity of a caretaker is unknown. Unknown is used when an investigation reveals that the child was physically abused or neglected, but the LDSS is unable to establish the identity of the responsible caretaker. If new information is received regarding the identity of the caretaker, a new investigation may be conducted.

As highlighted in Table 10, the race of the caretakers was primarily White (44.0%) and African – American (45.4%) and the percentages are significantly closer to one another than previous years.

Table 10: Race of Caretakers in Child Deaths from Abuse or Neglect
SFY 2018- SFY 2020

	SFY 2018		SFY 2019		SFY 2020	
	Number	**Percent**	**Number**	**Percent**	**Number**	**Percent**
African-American	22	39.2	26	35.1	25	45.4
White	28	50.0	41	55.4	24	44.0
Asian	0	0.0	2	2.7	1	2.0
Unknown	6	11.0	5	6.8	5	9.0
Multi-racial	0	0.0	0	0.0	0	0.0
Total Caretakers	**56**	**100.0**	**74**	**100.0**	**55**	**100.0**

Source: VDSS, July 2021. Information obtained from LDSS.

[7]Source: *Child Maltreatment 2019*. U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau.

As shown in Table 11, there are typically more female perpetrators of child maltreatment than male perpetrators.

Table 11: Gender of Caretakers in Child Deaths from Abuse or Neglect
SFY 2018-SFY 2020

	SFY 2018		SFY 2019		SFY 2020	
	Number	**Percent**	**Number**	**Percent**	**Number**	**Percent**
Female	35	63.0	43	58.1	30	54.5
Male	20	36.0	31	42.0	21	38.1
Unknown	1*	2.0	0	0.0	4	7.3
Total Caretakers	**56**	**100.0**	**74**	**100.1**	**55**	**100.0**

Source: VDSS, July 2021. Information obtained from LDSS.

As exhibited in Table 12, the ages of caretakers ranged from 13 to 60 years in SFY 2020. The majority of the caretakers (45.4%) were between 20 and 29 years of age.

Table 12: Age of Caretakers in Child Deaths from Abuse or Neglect
SFY 2018- SFY 2020

	SFY 2018		SFY 2019		SFY 2020	
	Number	**Percent**	**Number**	**Percent**	**Number**	**Percent**
Under 20 years	3	5.3	2	2.7	2	3.6
20 to 29 years	28	50.0	37	50.0	25	45.4
30 to 39 years	16	29.0	25	34.0	14	25.4
40 to 49 years	7	13.0	7	9.4	4	7.2
50 or older	1	1.8	1	1.3	3	5.4
Unknown	1	1.8	2	2.7	7	13
Total	**56**	**100.0**	**74**	**100.1**	**55**	**100.0**

Source: VDSS July 2021. Information obtained from LDSS.

IV. CATEGORIES OF ABUSE AND NEGLECT

In SFY 2020, 42 children died as a result of at least one type of abuse or neglect. Some children were abused or neglected in more than one way and by more than one caretaker. Of the children who died, 28 (67%) had been physically neglected and 13 (31%) had been physically abused. One (2%) child was medically neglected.

The type of abuse or neglect is not necessarily the *cause of death* for the child. For example, a child accidentally, fatally shot himself. The cause of death (determined by the medical examiner) would be gunshot wound of the head; the type of abuse or neglect (determined by CPS) would be neglect (failing to do something on behalf of the child).

As highlighted in Table 13, 28 (67%) of the child deaths involved some type of physical neglect. The two most prevalent types of neglect were Inadequate Supervision and Other/Unspecified sub-type. When determining the validity of a report, the alleged inaction by the caretaker may not clearly fit into the pre-defined sub-categories but still encompasses physical neglect so the Other/Unspecified sub-type is utilized by the LDSS.

Table 13: Types of Neglect in Child Deaths
SFY 2018- SFY 2020

	SFY 2018	SFY 2019	SFY 2020
Abandonment	0	0	0
Inadequate Supervision	8	14*	13*
Inadequate Shelter	1	0	0
Inadequate Food	0	0	1
Failure to Thrive	0	0	0
Medical Neglect	3	9	0
Other/Unspecified sub-type	13	14*	14

Source: VDSS, July 2021. Information obtained from LDSS.
There were three gun-related deaths that were founded for physical neglect

Medical neglect directly caused or contributed to the death of one (2%) child. Medical neglect involves a caretaker's failure to obtain a child's necessary medical care or to follow doctor-recommended medical regimen for the child. See the Table of Founded Child Deaths in **Appendix A** for further details.

As illustrated in Table 14, 13 (31%) children died as a result of physical abuse in SFY 2020.

Table 14: Types of Abuse in Child Deaths
SFY 2018 – SFY 2020

	SFY 2018	SFY 2019	SFY 2020
Asphyxiation (accidental or intentional	1	0	0
Bone Fracture	0	0	1
Burns	1	0	0
Bruises	3	1	2
Gunshot	2	1	0
Poisoning	1	0	0
Abusive Head Trauma	3	0	0
Stabbing	0	0	0
Internal Injuries	0	0	0
Head Injury	3	2	4
Chronic Physical Abuse[1]	0	0	0
Other or Unspecified Type	1	10	6

Source: VDSS, July 2021. Information obtained from LDSS.
[1]Chronic Physical Abuse, formerly known as Battered Child Syndrome.

V. FAMILIES AND THE CHILD WELFARE SYSTEM

When initiating a response to a child fatality report, CPS conducts an assessment of immediate harm or threat of harm toward any sibling(s) or other child(ren) in the home. Based on this initial safety assessment, a safety plan may be developed with the family for a course of action to mitigate any danger(s) or threat(s) of harm. The following information identifies those families and the resulting protective action taken by the LDSS.

As shown in Table 15, there were 42 households that involved 42 child death investigations resulting in founded dispositions for SFY 2020; 28 (67%) of those households had other children for whom initial safety was assessed. All of the remaining households had no other children in the home.

Table 15: Initial Safety Outcomes for Other Children in the Household
SFY 2018-2020

	SFY 2018	SFY 2019	SFY 2020
	# Families	# Families	# Families
Safety plan with family	5	14	4
Safety plan with relatives/family friends	12	15	23
Emergency removal/foster care	6	6	1
Total Families	**23**	**35**	**28**

Source: VDSS, July 2020. Information obtained from LDSS.

In SFY 2020, a plan was developed with 4 households that allowed the siblings to remain in their own homes. An additional 23 households placed their children in alternate living arrangements with relatives or family friends, while maintaining legal custody of their children, as part of a safety plan.

LDSS assessed siblings living in one household as unsafe and arranged for 1 child's placement in foster care.

As a result of CPS involvement, families were provided services that include: grief counseling; burial assistance; home visiting; parent education and mental health services; substance use assessments and treatment; intimate partner violence services; and protective orders.

As exhibited in Table 16, there were 42 victims (42 households) in founded CPS fatality investigations for SFY 2020; 21 families (50%) had prior or active child welfare involvement. Four families had an active case with an LDSS at the time of the fatality.

Table 16: Prior Family Child Welfare Involvement in Child Deaths from Abuse or Neglect SFY 2018- SFY 2020

	SFY 2018		SFY 2019		SFY 2020	
	# Families	**Percent**	**# Families**	**Percent**	**# Families**	**Percent**
Yes	24	60.0*	34	67.0*	21	50.0
No	16	40.0	17	33.0	21	50.0
Total	**40**	**100.0***	**51**	**100.0***	**42**	**100.0***

Source: VDSS, June 2021. Information obtained from LDSS.
Some families had prior history in more than one locality

Prior involvement means that the alleged abuser, victim child or siblings were previously the subject of a family assessment, an investigation, in-home service or foster care case. It does not include any caretaker's history of abuse or neglect that occurred as a child or any reports of suspected child abuse or neglect that did not meet validity criteria. Prior involvement also includes any open family assessment, investigation or case at the time of the child's death. It may also have occurred in more than one locality or a locality different from where the child died. The following summarizes the prior or current child welfare involvement of the families with founded fatality victims:

- In September 2018, a report was received for neglect by the mother involving the deceased child and siblings.
- In December 2014, a report was received for neglect by the parents involving a sibling of the deceased child. The sibling was temporarily placed in foster care, then with a relative and later placed permanently, through legal custody transfer with fictive kin. The investigation was founded. Services were provided.
- In February 2018, a report was received for neglect by the mother involving a sibling of the deceased child (born substance-exposed).
- In July 2019, a report was received for neglect by the parents involving the deceased child. Services were declined.
- In March 2019, a report was received for neglect by the parents involving the deceased child. In August 2019, a report was received for neglect by the father involving the deceased child. In September, 2019, a report was received for abuse by the father involving the deceased child and was open at the time of death.
- From 2015 to 2017, several reports were received for neglect by the parents involving the deceased child and siblings. They were temporarily placed into foster care. The investigations were founded and the parental rights were terminated. Services were provided.
- In November 2019, a report was received for neglect by a foster parent involving the deceased child. The investigation was unfounded, services were already being provided.
- In July 2018, a report was received for abuse by the mother's paramour involving a half-sibling of the deceased child. The paramour was criminally charged. The mother arranged for temporarily care of the sibling with fictive kin. The mother declined services.
- From 2012 to 2015, several reports were received for abuse and neglect by the father involving half-siblings. The investigation was founded. Services were provided and the father's paternal rights were later terminated.
- In January 2018, a report was received for neglect by the mother involving the deceased child.

- In August 2015, a report was received for neglect by the mother involving a sibling of the deceased child. In October 2017, a report was received for abuse by the father involving a sibling of the deceased child. The investigation was founded. Services were provided.
- In January 2019, a report was received for intimate partner violence with the parents with a sibling of the deceased child present.
- In December 2018, a report was received for neglect by the father involving the deceased child and a sibling.
- In January 2020, a report was received for abuse by the parents involving the deceased child. The investigation was founded. The parents arranged for the deceased child to live with fictive kin.
- In January 2019, a report was received for neglect by the parents involving the siblings of the deceased child. The mother was arrested for an outstanding criminal warrant; the siblings were temporarily placed into foster care. The investigation was founded. The custody of one sibling was granted to a relative; the other sibling is currently on a trial placement with relatives who live out of state.
- In July 2019, a report was received for neglect by the mother involving the deceased child and a sibling. The investigation was unfounded.
- From 2012-2015, prevention services were provided to the mother and siblings of the deceased child. From 2019-2020, several reports were received for abuse and neglect by the parents involving the siblings of the deceased child. Two of the investigations were founded. Services were provided and were being provided at the time of death.
- In December 2016, a report was received for a child death (half-sibling) who died of natural causes. The investigation was unfounded. In September 2019, a report was received for neglect by the mother involving a sibling of the deceased child. A second report was also received for IPV between the parents while a sibling was present. The father was criminally charged. The investigation was unfounded. In March 2020, a report was received for neglect by the mother involving the deceased child (born substance-exposed); it was open at the time of death.
- In March 2014, a report was received for abuse involving a relative and his child. The investigation against the relative was founded.
- In September 2017, a report was received for abuse by the mother involving siblings of the deceased child. The mother was criminally charged and the parents made arrangements for the siblings to stay with a relative. The investigation was founded and the relative was awarded custody of the siblings.
- In August 2014, a report was received for neglect by the mother involving a sibling of the deceased child (born substance-exposed). Services were provided.
- In June 2017, a report was received for neglect by the mother involving a sibling of the deceased child.
- In August 2018, a report was received for neglect by the mother involving the deceased child. The investigation was founded. Services were provided. In November 2018, a report was received for IPV between the parents. The father was criminally charged. The investigation was founded against the father and unfounded against the mother. Services were provided and were being provided at the time of death.

VI. UNFOUNDED REPORTS

In SFY 2020, there were 93 (67%) child fatality reports and investigations with an unfounded disposition. An unfounded disposition does not mean the abuse or neglect did not occur. An unfounded disposition means the investigation lacked a preponderance of the evidence to warrant a disposition of founded.

Of the 93 unfounded reports:

- Seventy-three of the reports (78%) involved a child less than one year of age.
- Forty-five of the 93 reports (48%) were sleep-related. This means the actual surface the child slept on, with whom the child was sleeping, or how the child was sleeping. This includes children who suffocated or accidently asphyxiated due to their sleep environment.

Many of the sleep-related child deaths resulted in a determination by a medical examiner that the cause of death was Sudden Unexplained Infant Death (SUID). SUID is a diagnosis of exclusion, made when there is an absence of pathological findings revealing injury, violence, disease, or other fatal medical condition. A SUID diagnosis recognizes a host of confounding factors, most importantly, the presence of unsafe sleep factors and/or medical problems such as pneumonia, prematurity or congestion[5].

VII. NEAR-FATALITIES

CAPTA (Child Abuse Prevention and Treatment Act) defines a "near fatality" *as an act that, as certified by a physician, places the child in serious or critical condition (22VAC40-705-10) "Life-threatening condition" means a condition that if left untreated, more likely than not will result in death and for which the recommended medical treatments carry a probable chance of impairing the health of the individual or a risk of terminating the life of the individual.*

There were 13 near-fatalities reported and investigated by LDSS for possible abuse or neglect. Four of the 13 children were under the age of one; four were between 14 and 23 months old and the remaining five children ranged in age from 2 to 10 years-old. Eighty-four percent (11) of the children were male and 15% (2) female. The race of the children was 23% African-American; 46% White, 23% Multi-Racial and one child was Asian. Nine of the 13 investigations (69%) were founded for abuse or neglect; two of the families had prior child welfare involvement.

VIII. APPENDICES

A. Table of Child Death Investigations with a Founded Disposition

B. Table of Child Death Investigations with an Unfounded Disposition

[8] Excerpt from Sleep-Related Infant Deaths in Virginia, a report from the Virginia State Child Fatality Review Team. http://www.vdh.virginia.gov/medExam/childfatality-reports.htm

IX. REGIONAL CHILD FATALITY REVIEW TEAM ANALYSIS

Regional Child Fatality Review Teams (CFRT) convene to examine deaths that local departments of social services (LDSS) investigated. CFRT focus on identifying risk factors, trends and patterns, developing recommendations and creating action plans. The *Code of Virginia,* specifically §32.1-283.2 provides the authority for the work of CFRT.

There is a CFRT, which is multidisciplinary in structure, in each of the five VDSS regions. Virginia is one of 45 states that utilize the National Center for Fatality Reviews and Prevention of Child Death Case Reporting Tool to document child fatalities. Review teams are required to enter results of the review process into the National Center for Fatality Review and Prevention's database.

In SFY 2020, the teams conducted reviews of the child deaths that occurred in SFY 2019. The COVID-19 pandemic necessitated the suspension of meetings from March to September 2020, when the meetings transitioned to a virtual platform.

Region	**Number of Cases Reviewed**
Central	7
Eastern	42
Northern	22
Piedmont	15
Western	10

Each Regional Child Fatality Review Team reports annually the significant findings and themes from the reviews as well as recommendations or initiatives that result from the team's discussion of that year's child death cases. Highlights of SFY 2020's regional recommendations:

- Increase training for mandated reporters on a variety of topics including trauma informed care, identifying signs of abuse or neglect, and VaCPS, the web-based reporting system for mandated reporters.

- Enhance public awareness campaigns related to safe sleep practices, gun safety, and heat related car deaths.

- Improve data collection and reporting of child maltreatment fatalities.

- Strengthen collaboration between law enforcement and CPS on joint investigations involving child deaths.

The prevention of child maltreatment deaths is essential to ensuring the well-being, safety and permanency of Virginia's children and remains a top priority for VDSS.